ARC 6781C

HUMAN SERVICES DEPARTMENT[441]

Adopted and Filed Emergency After Notice

Rule making related to medical and remedial care

The Human Services Department hereby amends Chapter 78, "Amount, Duration and Scope of Medical and Remedial Services," and Chapter 79, "Other Policies Relating to Providers of Medical and Remedial Care," Iowa Administrative Code.

Legal Authority for Rule Making

This rule making is adopted under the authority provided in Iowa Code chapter 249A.

State or Federal Law Implemented

This rule making implements, in whole or in part, Iowa Code chapter 249A and 2022 Iowa Acts, House Files 2546 and 2578.

Purpose and Summary

During the 2022 Legislative Session, 2022 Iowa Acts, House File 2546, which requires Iowa Medicaid to establish a rate for psychiatric intensive care in Iowa, was passed. 2022 Iowa Acts, House File 2578, which requires implementation of a tiered rate reimbursement methodology for psychiatric intensive inpatient care under the Medicaid program no later than January 1, 2023, was also passed.

This rule making defines "acute psychiatric intensive care" and identifies how a patient meets the need for that level of care. This rule making also identifies the payment methodology for the acute psychiatric intensive care services.

Public Comment and Changes to Rule Making

Notice of Intended Action for this rule making was published in the Iowa Administrative Bulletin on November 2, 2022, as **ARC 6619C**.

The Department received comments from three individuals representing two agencies. The comments and the Department's responses are listed below:

UnityPoint Health

UnityPoint Health acknowledged and thanked both the Iowa Department of Health and Human Services (HHS) and the Iowa Hospital Association for their efforts in convening a workgroup of interested stakeholders for the development of psychiatric intensive care Medicaid administrative rules and rates. UnityPoint Health was an active participant in the state-sponsored pre-rule-making sessions to develop these rules, and UnityPoint Health's feedback, along with that of other providers, was incorporated into the proposed rules. As such, UnityPoint Health generally supported the rules without substantive changes but did offer some operational feedback.

Comment 1: UnityPoint Health respectfully requested that HHS continue to monitor both minor and geriatric patients to evaluate future inclusion for psychiatric intensive care services.

Department response: The scope of the current rules was established to ensure timely implementation of 2022 Iowa Acts, House Files 2546 and 2578. Fiscal estimations that support the appropriation in House File 2578 were based on the limited demographic identified in the rules. The Department concurs that additional conversation regarding expansion of this rate to include minor and geriatric patients is merited in the future. Iowa Medicaid is developing a monitoring plan for ongoing evaluation of rate implementation that may help inform future conversations.

Comment 2: UnityPoint Health expressed concern that neither hospitals nor managed care organizations (MCOs) will have sufficient time to update their software systems by the effective date of these amendments. As a result, it is reasonable to believe that full program implementation will be

delayed and that billing start dates will vary by hospital and/or MCO as HHS and the Iowa Legislature evaluate the effectiveness of this program and the adequacy of rates. UnityPoint Health encouraged a deeper dive into program/service utilization to ascertain when rates would be fully able to be billed to make an informed judgment.

Department response: These amendments and associated rates are being implemented in an expedited fashion while maintaining a strong collaborative effort with affected partners. The MCOs have been actively engaged in development of claims processing and utilization management standards. A policy clarification was submitted to the MCOs November 9, 2022, to provide written documentation needed to ensure MCO system updates will be in place by January 2023. The same information was shared with the psychiatric intensive care workgroup, including hospitals and MCOs, throughout October and November 2022. The Department acknowledges even with these efforts, this is a new rate that will take time and education to fully implement across all Iowa hospitals. Iowa Medicaid is developing a monitoring plan for ongoing evaluation of the rules and rate implementation that will include monitoring program and service utilization.

During the public notice and comment period, the state workgroup discussed additional changes to the rules. UnityPoint Health reviewed these proposed revisions, which are included below. UnityPoint Health opposed some changes and supported others.

Comment 3: A change was proposed to remove the following phrase: "A history of violence or current aggression that is secondary to mental illness." UnityPoint Health disagreed with removing the phrase and stated that a history of and known propensity for violence should not be excluded as a factor that demonstrates complexity of care.

Department response: This comment was discussed with the state workgroup with parties both for and against removing the language. The Department has determined it will not remove the language since such a history could impact clinical decision making for maintaining safety for the member, other patients, staff, and the facility.

Comment 4: A change was proposed to modify language to read, "A highly disorganized psychotic state or manic thought process that impairs the ability to function, or the safety of the patient or others; or." UnityPoint Health disagreed with the inclusion of the subjective limiting adverb "highly." "Highly disorganized psychotic state" is not defined in the Iowa Code, and it is unclear what difference in documentation is required to prove disorganized psychotic state versus highly disorganized psychotic state. UnityPoint Health supported the suggested addition to the list of indicators that demonstrate complexity of need. This proposed revision adds "manic thought process" and also expands the manifestation for both conditions to include impaired function.

Department response: These modifications were discussed with the state workgroup. The term "highly" is being removed from the rule since it is subjective. The phrase "or manic thought process that impairs the ability to function or risks the safety of the patient or others" was added to provide additional clarity for providers.

Comment 5: A change was proposed to modify language to read, "Actively suicidal or homicidal; or." UnityPoint Health disagreed with the inclusion of the subjective limiting adverb "actively." "Actively suicidal" is not defined in the Iowa Code, and it is unclear what difference in documentation is required to provide suicidal versus actively suicidal. UnityPoint Health similarly disagreed with the inclusion of this subjective limiting adverb to modify "homicidal." In the alternative, UnityPoint Health supported removing this subpart in its entirety. It does appear that this subpart is redundant with subparagraph 78.3(8)"b"(2), which reads "have a current, severe, imminent risk of serious harm to self or others."

Department response: These modifications were discussed with the state workgroup. The phrase "actively suicidal or homicidal" will not be added to the rule. The phrase "or a highly suicidal state" has been removed. The Department concurs that the language is redundant of subparagraph 78.3(8)"b"(2).

Comment 6: A change was proposed to modify language to read, "Behavior that causes significant disruption to the general milieu of the unit (i.e., instigating other patients in negative ways); or." UnityPoint Health disagreed with this inclusion of the subjective limiting adjective "significant."

"Significant disruption" is not defined in the Iowa Code, and it is unclear what difference in documentation is required to prove disruption versus significant disruption.

Department response: This modification was discussed with the state workgroup. The Department concurs and did not add "significant" since it is a subjective term that cannot easily be measured.

Comment 7: A change was proposed to modify language to read, "Any other atypical reason that the admitting psychiatrist treating mental health provider feels that additional resources are needed to keep the patient and other[s] around the patient safe." UnityPoint Health supported this revision. UnityPoint Health agreed that providers should not be limited to a psychiatrist if other providers within the scope of practice and with appropriate privileges are able to treat such patients. In Iowa, this would allow advanced registered nurse practitioners to continue to be considered a treating mental health provider.

Department response: This modification was discussed with the state workgroup. The Department concurs that "admitting psychiatrist" should be modified to "treating mental health provider" and made this change. This modification will help avoid unintended limitations related to mental health providers in the inpatient setting.

Comment 8: The following language was proposed for paragraph 78.3(8)"c":

"*c*. The individual must have a documented need for acute intensive care requiring increased or specialized staffing, equipment, or facilities, based on two or more of the following:

"1. Fall risk, precaution protocol in place,

"2. Restraints or seclusion room required,

"3. Requires assistance with activities of daily living,

"4. Requirements for complex nursing care, nursing care requirements,

"5. Evaluation of patient status (alertness/orientation), acutely impaired cognitive functioning from baseline,

"6. Interventions to address the complexity of mental illness and comorbidities, documentation of interventions to address acute complex mental illness and comorbidities,

"7. Safety protocols in place to address the physical risk posed to staff, other patients, and infrastructure,

"8. Elopement risk precaution protocol in place."

UnityPoint Health commented, "As described by state officials, the intent for these revisions is to identify a level of risk that requires documentation and to assure that services provided are mitigating the risk that is identified. These rules are not intended to require that all facilities have the same protocols but rather that all facilities are using protocols to identify risk. For example, each hospital should have protocols in place which determine if a patient is at risk for falls. UnityPoint Health support[s] evidence-based [care] and protocols and is reassured to understand that these rules are not intended to require additional or different protocols than are in place today."

Department response: These modifications were discussed with the state workgroup. The modifications are intended to create clarity for both providers and utilization management review teams. The modifications maintain the intent of the original language while creating measurable documentation standards. The Department concurs with UnityPoint Health's statements on the intent of these revisions.

The workgroup discussed the HHS draft clinical criteria for Acute Psychiatric Intensive Care Services (LOC-008), although the criteria were not included in the Notice. The goal of these specialized services is acute stabilization and treatment of the member's presenting condition, including dangerous behavior, so that the member can transition to a general inpatient psychiatric unit or another less-intensive level of care.

Comment 9: UnityPoint Health appreciated the time and effort of HHS in developing these clinical criteria and has provided additional considerations below as they relate to exclusion criteria #6.

"Exclusion Criteria #6: Behavioral dyscontrol in the context of traumatic brain injury, intellectual disability, pervasive developmental disorder, dementia, or other medical condition without indication of acute crisis related to a diagnosis listed in the [most] current version of the Diagnostic and Statistical Manual of Mental Disorders."

UnityPoint Health commented, "While the clinical criteria specify psychiatric intensive care unit (PICU) services are directed towards assisting individuals with acute mental illness as opposed to other

mental conditions, it should be noted that further appropriation of resources is needed for patients with other mental conditions as identified in exclusion criteria six. Often individuals with these conditions are boarded in hospital emergency departments or admitted to inpatient psychiatric units due to severe lack of treatment options, e.g., access centers, long term care facilities, and Intensive Residential Service Homes. With limited treatment options available, individuals listed in exclusion criteria six, will lack adequate access to PICU level care or be placed in care settings inappropriate or unequipped to manage severe and emergency behavioral health care."

Department response: The exclusion criteria identified in UnityPoint Health's comment are consistent with the intent and scope of the rule. The establishment of a psychiatric intensive care rate will help support acute care inpatient intensive psychiatric services, but the implementation of rate does not resolve the overall lack of treatment options identified in UnityPoint Health's comment. Iowa Medicaid is a willing partner in working to address larger challenges to Iowa's mental health system.

Iowa Hospital Association

Comment 10: As HHS prepared to create the rule making to effectively implement 2022 Iowa Acts, House File 2546 and House File 2578, Iowa Hospital Association (IHA) is appreciative of the opportunity to include a broad audience of experts in hospital settings which includes behavioral health directors and providers as well as government relations and finance professionals. It was brought to IHA's attention that Iowa is the first in the nation to implement such a reimbursement methodology, and IHA's members are proud to be part of the opportunity in leading the nation alongside the Department to increase behavioral health resources.

Department response: The Department appreciates the IHA's support and engagement. The workgroup consisted of subject matter experts within Iowa Medicaid, representatives from multiple hospitals, clinical providers, IHA representatives, representatives from the Tertiary Care workgroup, Iowa's MCOs claims teams, utilization management teams, and medical directors (representatives from Amerigroup, Iowa Total Care, and Molina). This workgroup collaborated to develop the rate, rules, state plan amendments, claims processing and utilization management standards, and training materials to implement House Files 2546 and 2578.

Based on the comments received, the Department made changes from the Notice to numbered paragraphs 78.3(8)"b"(3)"5" and "8" and subparagraphs 78.3(8)"c"(1) and (4) through (8).

Reason for Waiver of Normal Effective Date

Pursuant to Iowa Code section 17A.5(2)"b"(1)(a) and (b), the Department finds that the normal effective date of this rule making, 35 days after publication, should be waived and the rule making made effective on January 1, 2023, because 2022 Iowa Acts, House File 2578, sections 31 and 32, authorize emergency rule making. The rule making also confers a benefit to members and providers by allowing the service to be available as of January 1, 2023.

Adoption of Rule Making

This rule making was adopted by the Council on Human Services on December 8, 2022.

Fiscal Impact

It is anticipated there will be a $1.5 million state cost in state fiscal year 2023 and a $3 million state cost in state fiscal year 2024 with the assumption that the implemented rate will be developed to align with the funding appropriated. The Legislature has not yet appropriated the full annualized cost.

Jobs Impact

The additional funding may be utilized for increased staffing ratios, but it is unlikely a significant number of jobs will be created.

Waivers

Any person who believes that the application of the discretionary provisions of this rule making would result in hardship or injustice to that person may petition the Department for a waiver of the discretionary provisions, if any, pursuant to rule 441—1.8(17A,217).

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rule making by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rule making at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

Effective Date

This rule making will become effective on January 1, 2023.

The following rule-making actions are adopted:

ITEM 1. Adopt the following **new** subrule 78.3(8):

78.3(8) Payment will be made for medically necessary inpatient acute psychiatric intensive care services that meet the criteria in this subrule, pursuant to 441—paragraph 79.1(5)*"i."* This inpatient rate is only applicable to individuals 18 to 64 years of age. All inpatient acute psychiatric intensive care services shall require prior authorization.

a. "Acute psychiatric intensive care" is defined as care provided for a condition with rapid onset that is accompanied by severe symptoms and is generally of brief duration, requiring emergency treatment and critical care.

b. To meet the need for acute psychiatric intensive care, the patient must:

(1) Have a serious mental illness as defined in 441—subrule 77.47(1);

(2) Have a current, severe, imminent risk of serious harm to self or others; and

(3) Display additional complexity of need related to:

1. Complex comorbidities, including intellectual or developmental disability, autism spectrum disorder, substance use disorders, or traumatic brain injuries; or

2. A history of violence or current aggression that is secondary to mental illness; or

3. A request for patient transfer that has been rejected by inpatient level of care by one or more hospitals due to severity of symptoms; or

4. Lack of responsiveness to typical interventions or a condition that is treatment refractory; or

5. Disorganized psychotic state or manic thought process that impairs the ability to function or risks the safety of the patient or others; or

6. Behavior that causes disruption to the general milieu of the unit (i.e., instigating other patients in negative ways); or

7. High elopement risk; or

8. Any other atypical reason that the treating mental health provider feels that additional resources are needed to keep the patient and others around the patient safe.

c. The individual must have a documented need for acute intensive care requiring increased or specialized staffing, equipment, or facilities, based on two or more of the following:

(1) Fall precaution protocol in place;

(2) Restraints or seclusion room requirements;

(3) Requiring assistance with activities of daily living;

(4) Requirements for complex nursing care;

(5) Acutely impaired cognitive functioning from baseline;

(6) Documentation of interventions to address acute complex mental illness and comorbidities;

(7) Safety protocols in place to address the physical risk posed to staff, other patients, and infrastructure;

(8) Elopement risk precaution protocol in place.

ITEM 2. Amend paragraph **79.1(5)"i"** as follows:

i. Payment for certified physical rehabilitation hospitals and units, ~~and~~ psychiatric units, and acute psychiatric intensive care services. Payment for services provided by a physical rehabilitation hospital or unit certified pursuant to paragraph 79.1(5)*"r"* and for services provided on or after October 1, 2006, in a psychiatric unit certified pursuant to paragraph 79.1(5)*"r"* is prospective. The payment is based on a per diem rate calculated for each hospital by establishing a base-year per diem rate to which an annual index is applied.

(1) Per diem calculation. The base rate shall be the medical assistance per diem rate as determined by the individual hospital's base-year cost report pursuant to paragraph 79.1(5)*"a."* No recognition will be given to the professional component of the hospital-based physicians except as noted under paragraph 79.1(5)*"j."*

~~(2) Reserved.~~

~~(3)~~ (2) Per diem reimbursement. Hospitals shall be reimbursed the lower of actual charges or the medical assistance cost per diem rate. The determination of the applicable rate shall be based on the hospital fiscal year aggregate of actual charges and medical assistance cost per diem rate. If an overpayment exists, the hospital will refund or have the overpayment deducted from subsequent billings.

~~(4)~~ (3) Per diem recalculation. Hospital prospective reimbursement rates shall be established as of October 1, 1987, for the remainder of the applicable hospital fiscal year. Beginning July 1, 1988, all updated rates shall be established based on the state's fiscal year.

(4) Acute psychiatric intensive care services. Services that meet the criteria at 441—subrule 78.3(8) shall be reimbursed as follows:

1. Services provided in a psychiatric unit certified pursuant to paragraph 79.1(5)*"r"* will be paid based on the hospital-specific per diem rate as calculated pursuant to subparagraph 79.1(5)*"i"*(1) plus a percentage increase as determined by the department for covered days billed with the appropriate psychiatric intensive care revenue code.

2. Services not provided in a psychiatric unit certified pursuant to paragraph 79.1(5)*"r"* will be paid based on the hospital-specific DRG payment rate as calculated pursuant to paragraph 79.1(5)*"b"* plus an add-on per diem rate as determined by the department for covered days billed with the appropriate psychiatric intensive care revenue code.

(5) Per diem billing. The current method for submitting billing and cost reports shall be maintained. All cost reports will be subject to desk review audit and, if necessary, a field audit.

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EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 12/28/22.